Group Claim Fraud Statements

The following fraud language is attached to, and made part of this claim form. Please read and do not remove these pages from this claim form.

** **Alaska:** A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

** **Arizona:** Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

** **California:** For your protection California law requires the following to appear on this form. Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

** **Colorado:** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

** **Delaware:** Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

** **District of Columbia:** WARNING: It is a crime to provide false or misleading information to an insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

** **Florida:** Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

** **Idaho:** Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement containing any false, incomplete, or misleading information is guilty of a felony.

** **Kentucky:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

** **Maryland:** Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

** **Maine:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

** **Minnesota:** A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

** **New Hampshire**: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment of insurance fraud, as provided in RSA 638:20.

** **New Jersey:** Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

** **New Mexico:** ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND PENALTIES.

** **Ohio:** Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

** **Oklahoma:** WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

** **Pennsylvania:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

** **Puerto Rico:** Any person who knowingly, and with intent to defraud or deceive any insurance company includes false information in an application for insurance or files, assists, or abets in the filing of a fraudulent claim to obtain payment of a loss or other benefits, or files more than one claim for the same loss or damage, may be guilty of a felony. Upon conviction, that person will be fined between $5,000 and $10,000, imprisoned for three (3) years or both. Aggravating or attenuating circumstances may result in the prison term being increased to five (5) years or reduced to two (2) years.

Cualquier persona quien con conocimiento y con la intensión de defraudar o engañar a cualquier compañía de seguros, incluye información falsa en una solicitud para seguro o introduce, o instiga en la introducción de una reclamación fraudulenta para obtener pago por una pérdida u otro beneficio, o presenta más de una reclamación por la misma pérdida o daño puede ser culpable de cometer un acto criminal. Al ser convicto, ese persona será multada con una cantidad de $5,000 a $10,000, encarcelamiento por tres (3) años o ambos. Circunstancias agravantes o atenuantes podrían resultar en que el período de tiempo de prisión aumente a cinco (5) años o se reduzca a dos (2) años en concordancia.

** **Arkansas and Louisiana:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

** **Indiana:** A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

** **Rhode Island:** Any person who knowingly presents a false or fraudulent claim for the payment of a loss or knowingly presents false information in an application for insurance, is guilty of a crime and may be subject to fines and confinement in state prison.

** **Tennessee, Virginia, and Washington:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

** **Texas:** Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

** **If you live in a state other than mentioned above, the following statement applies to you:** Any person who knowingly, and with intent to injure, defraud or deceive any insurer or insurance company, files a statement of claim containing any materially false, incomplete, or misleading information or conceals any fact material thereto, may be guilty of a fraudulent act, may be prosecuted under state law and may be subject to civil and criminal penalties. In addition, any insurer or insurance company may deny benefits if false information is related to a claim by the claimant.

Group Benefit Services Application for Accidental Death Benefits

Please Return Completed Form To:
United of Omaha Life Insurance Company
Group Life Claims
Mutual of Omaha Plaza
Omaha, NE 68175
Toll Free 1-800-775-8805

Certified Copy of Death Certificate Must be Furnished With This Proof.

Statement of Beneficiary or Other Claimant

1. Your full name _____ Date of Birth _____
2. Your relationship to deceased _____
3. Full name of deceased _____ Deceased's date of birth _____
4. Last legal address of deceased _____
   Street City or Town State
5. State date of accident upon which claim is based _____
6. How did the injury occur? _____
7. Your telephone number _____
8. What injury or injuries were received? _____
9. Who was present when the deceased was injured? (Give full names and addresses) _____
   _____
10. Was an inquest held? _____ 11. Was an autopsy held?_____
12. State name and address of doctor first called after this injury. Also, name of doctor who attended deceased at time of death ____
    _____
13. Was deceased sick from any cause within five years preceding death? _____
    If so, state name of disease and name and address of the physician who attended him or her in such sickness _____
    _____
14. Does the deceased have any other life insurance coverage with Mutual of Omaha? Yes _____ No _____

Please attach a copy of the police report and toxicology records.

Authorization To Disclose Personal Information

To physicians, medical or dental practitioners, hospitals, clinics, pharmacies, pharmacy benefit managers, other medical care facilities, health maintenance organizations, insurers, employers, consumer reporting agencies and all other providers of medical or dental services.

I authorize you to release to representatives of United of Omaha Life Insurance Company, personal information about the insured person including: medical history, mental and physical condition, prescription drug records, alcohol or drug use, financial and occupational information in order to evaluate my claim for benefits.

If the person or entity to whom information is disclosed is not a health care provider or health plan subject to federal privacy regulations, the information may be redisclosed without the protection of the federal privacy regulations.

I understand that I may refuse to sign this authorization. I realize that if I refuse to sign, my claim for benefits may not be paid.

This authorization will expire 24 months after the date signed. I may revoke this authorization at any time by written notice to; ATTN: Group Life Claims, United of Omaha Life Insurance Company, Mutual of Omaha Plaza, Omaha, NE 68175-0001. Any revocation of this authorization will not affect any use or disclosure of Personal Information that occurred prior to the receipt of my revocation.

I understand that I am entitled to receive a copy of the authorization and that a copy is as valid as the original.

Name(s) used for medical records (if different than the name below): _____

_____

_____ _____ _____
Printed Name of Insured Person Printed Name of Authorized Person Signature of Authorized Person

_____ _____
Relationship to Insured Date

Statement of Attending Physician

1. Name of deceased _____
2. Where and when did you first attend deceased? _____
3. Was deceased hospitalized? _____ Name of hospital _____
4. Describe deceased's condition on your first visit _____
5. Were there any symptoms or signs of disease? Yes _____ No _____ If "Yes," describe _____
6. Give date of accident _____
7. Were there any visible contusions or wounds on the body of deceased? _____
8. What was the nature and extent of the injuries? _____
9. What was the date of death? _____
10. What was the primary cause of death? _____
11. Did any disease or cause, other than the injury referred to, complicate or contribute to the cause of death? _____

    If so, what? _____
12. Was the injury described above, independently of all other causes, sufficient to cause death? _____
13. If a postmortem examination was made, what were the findings as to cause of death? _____
14. Give names and addresses of other physicians or surgeons, if any, who attended deceased after the injury _____

Date _____ _____
Attending Physician Sign Here

Street Address _____ City _____ State _____ ZIP Code _____

Statement of Master Policyholder or Group Administrator

1. Full name of deceased _____ Soc. Sec. No. _____ Eff. date of insurance _____

   Name of Employee _____ Soc. Sec. No. _____ Eff. date of insurance _____
2. Date employment began _____ Occupation at time of death _____
3. Date of last active work _____ If retired, date retired _____
4. Premium for the above deceased has been paid through _____
5. If date deceased last worked was more than 31 days prior to death, was deceased:
   totally disabled? ☐ on leave of absence? ☐ on temporary layoff? ☐
6. If benefits are based on earnings, give amount of monthly earnings _____
   (Note: We may require supporting documentation of earnings and paid premiums to process the claim.)
7. If your plan has more than one class, show class deceased was covered under _____
8. Name of beneficiary shown on your records _____ Relationship _____

   Note: Attach Original Enrollment Record Plus any beneficiary changes.
9. Amount of Benefit: AD&D $ _____ Felonious Assault $ _____ Vol AD&D $ _____
   Common Carrier $ _____ Seat Belt $ _____ Airbag $ _____
   Repatriation (attach bill) $ _____ Repatriation: miles from residence _____

Master Policy No. _____ _____
Name of Policyholder

Date _____ By _____
Signature and Title